

**4.1.1.5 Surrogate Markers of HIV Risk Behaviors.** Syphilis and gonorrhea are reportable diseases in all states; reporting requirements for other STDs vary among states. Reporting levels are generally less complete compared with reporting of AIDS cases, and reporting is likely to be most complete among persons receiving STD services in the public sector. Because STDs result from unsafe sexual behaviors, their occurrence is a reflection of the level of unsafe sexual activity resulting in disease transmission in a community. Syphilis rates are probably a better reflection of HIV risk than gonorrhea rates. While STD rates provide a measure of unsafe sexual behaviors, they do not necessarily correlate with HIV risk, which depends both on the level of unsafe sexual activity and the level of HIV infection among networks of sexually active people. In some areas, STD rates may correlate strongly with HIV risks; in other areas they are more likely a measure of the potential for HIV transmission.

Trends in STD rates may provide a good indication of dynamic changes in the community that directly affect HIV transmission. For example, declines in rectal gonorrhea rates among men during the 1980's were viewed as a reflection of changing sexual norms in the gay community (although those changes have not been uniform or uniformly sustained as demonstrated by information from more recent surveys). Increases in syphilis in tandem with the crack cocaine epidemic demonstrated the potential for increased heterosexual transmission of HIV in the "crack house" milieu. However, trends in syphilis cases within local areas may reflect the status of local syphilis epidemics, and increases or decreases in syphilis rates may not correlate with variations in HIV risk.

Like HIV, hepatitis B is transmitted by sexual contact, through exposure to blood, perinatally; and it is a reportable disease in nearly all states. Hepatitis B case reports may also provide information on exposure risks (e.g., male-to-male sexual contact, illicit drug injection). Thus, trends in hepatitis B cases may reflect changes in behavior associated with HIV risk. However, in many areas, hepatitis B reporting is passive (e.g., health department staff do not actively solicit case reports from care providers), and thus completeness of reporting is less than for AIDS cases.

Other markers of sexual activity are less direct measures of HIV risk. For example, measures of adolescent fertility (abortion and birth rates) can estimate the level of unprotected intercourse among heterosexual teenagers. However, these measures do not necessarily predict the risk of disease transmission. Adolescent abortions suggest pregnancies that were not intended.

**4.1.1.6 Other Data Sources.** Information on persons who receive HIV counseling and testing services, including the number of positive tests, should be available from local counseling and testing services. These data can provide information on the number of HIV tests that are conducted at these sites, the characteristics of persons who use these services, and the percentage of tests that are positive. Based on interviews of persons reported with AIDS cases, these sites account for less than a third of HIV diagnoses (other common sites include hospitals and private physician offices).

Information on illicit drug use may be available from state alcohol and drug agencies. This may include estimates of the number of drug injectors, the number of treatment positions available and the length of waiting lists, and patterns of illicit drug use obtained from the Drug Abuse Warning Network (DAWN).

In preparing for the community planning process, each health department will need to assess the availability of information on HIV/AIDS and risk behaviors for its jurisdiction and to assemble this information into a package that will be useful to the community planning group. This includes the use of data from public health surveillance systems described in this document and data from other sources that may be available from local research projects. The strengths and limitations of these data as measures of risk behaviors and as a correlate of HIV infection must be assessed.

## **4.2 INVENTORY OF HIV/AIDS DATA SOURCES FOR PREVENTION PLANNING**

This section is organized by the level of availability of the data: information collected by all or nearly all states; information collected by many states; and information collected by selected states. In most instances, these data sets are supported by the Centers for Disease Control and Prevention (CDC) through cooperative agreements, which includes funding as well as technical support for data management systems that enable local tabulation. Thus, for the most part, these data should be available from county or state health departments. Table 4-1 summarizes these data sources.

Policies for the release of these data are guided by the importance of maintaining their confidentiality. In addition to strict proscriptions against releasing names (or other identifying information) of persons with HIV infection